Preventing War

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GUEST EDITORIAL

AT the time of writing, end of March 1991, one month after the end of hostilities in the Gulf war, an accurate inventory of all casualties, civilian and military, including the period since the invasion of Kuwait by Iraq on August 2, 1990, is still not possible; moreover, civil war has ensued within Iraq, as well as mass repression against the Kurd population, thereby adding to the victim toll. Just during the first, essentially aerial, phase of the war, from January 17 to February 23, 1991, some 90,000 sorties were made by the allied air forces (1). Taking this as a crude overall marker of war activities and speculating that, unless the bombs were sent to deserted areas, one major casualty, i.e., a death or severe injury, could result from anything between one and ten sorties, the casualty toll for the first phase alone might run in the tens of thousands. This fits with the likely span of figures quoted for the Iraqi deaths during the 43 days of the Gulf war, ranging from 100,000 (2) down to the entirely unspecified "not a great number" (3). It should be kept in mind that some 30,000 deaths would approximately amount to the doubling—during the war period—of the crude death rate of the Iraqi population.

The casualty toll demonstrates once more that, irrespective of how much a war can be seen, from one's own viewpoint, as ethically and legally just or politically and economically justifiable (or even necessary), a major result is loss of human lives and permanent or transient injury, physical or psychological, to the lives of others. Health damage invariably accompanies wars. From a public health perspective war can be regarded as an epidemic disease—or, as for some chronic civil wars, an endemic one—that once it escapes prevention cannot be fully controlled at later stages: at the best the number and severity of casualties can be limited. Casualties of which fighting side? Economic calculations and economy-

based choices in the health domain encounter several difficulties, some of the most fundamental stemming from the need to translate into quantitative estimates the value of human lives when comparing costs and expected benefits of intrinsically heterogeneous interventions (4): for instance, when having to allocate limited resources either to establishing a heart transplant service for adults or a screening facility for a congenital defect in newborns. Yet, within the frame of reference of peace, open and extensive discussions by a variety of involved parties can take place to settle by social consensus what may appear at first as irreconcilable issues of values.

In war no consensus solutions exist. Even within each of the battling sides open analyses of the relative values of the lives at stake are eschewed, lest too much light is focused on the kind of choices implicit and actually made in war, often in an expeditious, oversimplified way, with little, if any, room for consultation: choices between, say, the risk of sacrificing some of the enemy civilians, including children, through bombing a military position installed in a village, and the risk of exposing advancing soldiers to the position's fire. Alternatives and decisions of this nature, often involving sizable numbers of lives, are inevitable for anyone, however humane and rational, exercising his rationality within the frame of reference of war, irrational in its very foundation, as it brutally equates what is right with what is gained by violence. Moreover, human behaviour, especially when faced with life and man-inflicted death, can hardly be simplified to "rational" acting of the kind assumed, for instance, in abstract economic models.

It may be argued that in von Clausewitz's dictum (5) that "war is a simple continuation of politics by other means," the key word is "other" as the means of war are *not* merely passive instruments to an end. To be activated they first require a change in the value system prevailing in peace, and to turn out effective they usually include among the results the loss of human lives, an outcome alien to peace.

Preventing the loss of human lives from war is a pertinent concern for public health professionals, as is prevention of other violent deaths. The escalating number of war deaths in this century—sixty million and more deaths in the two world wars alone (6)—and the catastrophic scenarios for health and the environment which could derive from nuclear war have prompted, particularly over the last decade, some incisive actions against nuclear war, recognized by the Nobel Prize for Peace conferred in 1985 on "International Physicians for the Prevention of Nuclear War."

The injuries to life and health, direct and indirect (for example, through environmental deterioration) of the Gulf war demand renewed initiatives to prevent *all* forms of war, including those started as international "police operations" with the executive assent of the United Nations. This label, any more than the label "in the name of God," does not exempt them from scrutiny of their reasons, ends, means and actual results, among which human losses from all sides stand prominent. Those most directly involved in prevention, such as public health professionals and epidemiologists, can take the lead, along at least two lines:

1. *Professional awareness, education and training.* First, a firm change in perspective is needed, from regarding the prevention of war as only a political affair to considering it as the instrument for primary prevention of war deaths and injuries and, as such, a facet of public health. Second, the epidemiology of health consequences of war has to be given much more attention than now. There is a correct dictum stating that the first victim of any war is truth, and this applies to truth about health damages as well. There are three elements concurring to produce this result: the inherent difficulty of proper counting in the often chaotic situations of war, the interest that each party has in concealing from the enemy or forging information vital to the conduct of operations, and the stake that one or all parties have in minimizing the information on and visibility of human losses, lest war becomes an unpopular choice. Countering the lack of information cannot be improvised at the time of a war, but requires searching for and setting in place *ad hoc* mechanisms in advance. More generally, research on "war epidemiology" should be promoted, as well as feasible approaches to overcome the problem represented by the classified nature of needed military data. Available knowledge on epidemiological and preventive aspects of health damage from war should form a chapter in the teaching of public health, the subject for specialized short courses, and the content of educational seminars for the public health profession at large. In the agenda of public health ethics a place has to be made to discuss the ethical duties of public health professionals in the prevention of mass man-made deaths.

   Obviously, war prevention goes well beyond what epidemiologists and public health professionals can do alone. However, this is not exceptional, as the prevention of most other major health hazards,

like tobacco use, also depends to a substantial extent on actions at the social and political levels beyond the direct responsibility of the professionals. Their collective voice, nationally and internationally, can be, however, a powerful instrument of persuasion.

2. *Action against arms.* It is reasonable to maintain that a gross relationship exists between the risk of war, and of casualties within it, and the size of the available armaments pool. The Gulf war has been materially possible because of the weaponry bought by Iraq and sold to it by countries as varied as Austria, Brazil, China, Czechoslovakia, Egypt, France, FRG, Italy, South Africa, UK, USA, and USSR (7, 8). An arms-free world is not for today, and it may not be for tomorrow, but to accept an essentially *uncontrolled* production and free world trade of arms is to jeopardize both present and future. Successful field testing is the best form of advertisement, and the best performing weapons in the Gulf may soon enjoy a wide distribution to old and new markets, unless effective controls are now introduced. There are already indications of this happening (9). Actions targeted towards restricting production and trade in arms may include: (1) detailed, quantitative documentation and analyses of the double wastage arms represent in health terms for developed and developing countries alike (resources are engaged which could be invested in the health sector, and, when the arms are used, health is injured); (2) periodical public campaigns, in the same way as is done for other important health hazards; (3) delineation of country- or region-specific mechanisms to discourage and reduce arms production and trade, if possible coupled with channeling resources to the health sector (is, for example, a transfer tax unworkable?).

The Gulf crisis has shown once more that late-stage attempts to avert war, once all determining conditions are in place, have a high chance of failure, whatever the combined efforts, genuine or ritualistic, of the politicians, diplomats and military. War prevention has to start well beforehand, through long-term actions to which, as professionals involved in public health, we are called on to contribute.

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